

Application for License to
Operate a Long-term Care Facility

Trilogy Healthcare Services, LLC

For Office Use Only
Received 10/6/11
Amount 720.00

386143

RECEIVED

OCT 06 2011

OFFICE OF INSPECTOR GENERAL

I. IDENTIFICATION

Name Cedar Ridge Health Campus

Address 1217 U.S. Highway 62E

City/County/Zip Cynthiana, KY 41031

Telephone number (859) 234-2702

Administrator Melissa Larmour

Date facility operation began at current address February 2005

Date facility began operation under current owner September 1, 2002

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled

Nursing Home

Nursing Facility

Intermediate Care

ICF/MR

Personal Care

48

48

II. CONTROL (check one in each column)

State

County

City

☒ Private

☒ Profit

☐ Nonprofit

Individual

Partnership

☒ Corporation

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Trilogy Health Services, LLC

1650 Lyndon Farm Court, Suite 201

Louisville, KY 40223

(OVER)

10/31

If facility owned or leased by a corporation, complete the following:

Name of corporation _____

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

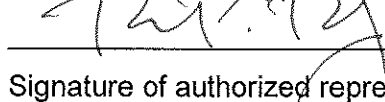
Parent
Trilogy Health Services, LLC

1650 Lyndon Farm Court, Suite 201

Louisville, KY 40223 _____

Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.



Signature of authorized representative

Paul Plevyak, SVP - Finance

Title

9-26-11

Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)